

JUSTA FARM DENTAL ESTHETICS

WE WOULD LIKE TO GET TO KNOW YOU BETTER

(This information is necessary for our files and your health and will be considered CONFIDENTIAL)

Date _____

Name _____ Spouse's Name _____

Married Single Divorced Widowed

Birthdate _____ Age _____ Male Female

Address _____ City _____ Zip _____

Home Phone No. _____ Social Security No. _____

Cell Phone No. _____ E-Mail Address _____

Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Spouse's Employer _____ Occupation _____

Business Address _____ Business Phone _____

Whom can we thank for referring you? _____

IF THIS IS FOR YOUR CHILD, PLEASE FILL OUT THIS SECTION ALSO

Name _____ Birthdate _____ Male Female

Address _____ City _____ Zip _____

Home Phone No. _____ School _____

DENTAL INSURANCE INFORMATION

Primary Carrier: Insurance Company _____

Group No. _____ Name of Insured _____

Date of Birth _____ Social Security No. _____

Secondary Carrier: Insurance Company _____

Group No. _____ Name of Insured _____

Date of Birth _____ Social Security No. _____

If husband and wife both have dental insurance, both policies must be submitted. Withholding any insurance information, whether primary or secondary, is unlawful.

Signature _____

I understand that all bills with Justa Farm Dental Esthetics that I have accumulated and which have not been covered by my insurance company, will be fully paid by me.

Signature _____